Discharge planning

Grand Round – 26th Sept 2018

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Aims

- Recognise common elements of the discharge-planning process
- Describe multidisciplinary team working in discharge planning
- Describe how you would deal with a complex discharge
- Discuss the key issues to consider if a patient refuses to be discharged

Questions I want you to ask (yourself)

- When will my patient be MFFD?
- Does my patient have rehab potential?
- What discharge options are there?
- How can I help with discharge planning?

Disclaimer

It’s complex…

…and…

…I’m not an expert

What is discharge planning?

- A process whose goal is to achieve the coordination of services needed by a patient after they leave hospital.
  - 'Bridge the gap' between hospital and home
  - Reduce LoS and unplanned readmission
- Effective discharge planning improves patient satisfaction/QoL and reduces readmission (Preyde 2009, JEBSW; 6:198-216)
- 43% carers feel inadequately supported following discharge (Carers UK)

Your role in discharge planning

Doctors need:

- A good understanding of the medical problems of the patients in their care - including prognosis, ongoing treatments and investigations that may influence functional outcome
- An ability to communicate these points clearly
- To appreciate the clinical roles of other team members, and refer appropriately

Key aspects of planning discharge

- Set an EDD as early as possible
- Identify whether a patient has simple or complex discharge planning needs
- Identify what those needs are (and how they might be met)
- Set criteria that a patient must meet for discharge

Estimated date of discharge (EDD)

- ‘The day we currently expect in-patient care requiring senior review to be completed if all treatment, investigations and procedures take place as required with progress made as anticipated’
  - should be in place within 24 hours of admission
  - amended only for clinical reasons (as many times as required)
  - not adjusted for recognised internal or external delays in ideal care
- Purpose (Lees & Holmes, 2005):
  - Strategic: to predict overall hospital capacity
  - Operational: to assess progress and outcomes of clinical plans
  - Individual: to help patients understand expectations, limitations and what is required from them in the discharge-planning process

Case 1

- Mr Black is 60. He was admitted with CCF and is feeling much better. His bloods are normal and he is mobilising independently around the ward.

- Is he MFFD?
- What is next step?

Case 2

- Mrs White is 70. She was admitted with CCF and is feeling much better, but requires oxygen overnight and is having daily blood tests. She mobilises to the bathroom with assistance.

- Is she MFFD?
- What is next step?

Case 3

- Prof Purple is 75. He was admitted with CCF and is feeling much better. He also has COPD and is on oxygen/nebulisers/IV antibiotics/IV fluids/XXXX*. He is mobilising and wants to go home.

** other ongoing medical intervention*

- Is he MFFD?
- What is next step?

Case 4

- Mr Green is 85. He was admitted with CCF and is feeling much better. He is mobilising with supervision but is intermittently confused.

- Is he MFFD?
- What is next step?

Case 5

- Miss Pink is 95. She was admitted with CCF and has had a long admission with multiple complications. She has not been out of bed for a week and is confused. Her oral intake is poor. Her blood tests have reached a new (worse) baseline.

- Is she MFFD?
- What is next step?

Has my patient got rehab potential?

Questions to ask:

- What was their baseline?
- What can they do now?
- What is stopping them from doing better?
- Are they MFFD?
- Has PT/OT seen them?
- Are they motivated?

The complex discharge

Options:

- Home +- voluntary services
- Home with reablement (short-term carers or domicilary-rehab)
- Home with POC
- Live with family +- support services
- Intermediate care (further assessment bed or residential rehab)
- Short-term placement
- Care home placement
  - Residential
  - Nursing
  - EMD / EMI / Challenging behaviour unit

Who pays?

- LA means test
  - takes account of capital, savings and income
  - Assets < £14,250 - LA pays
  - Assets £14,250-£23,250 – LA contributes
  - Assets > £23,250 – self-funding
- Exceptions:
  - NHS CHC
  - Fast track
  - Rapid access

NHS Continuing HealthCare (CHC)

- For patients with complex care needs.
- NHS pays for ‘social’ care.
- Procedure: checklist / DST / panel

- CHC checklist:
  - Behaviour
  - Cognition
  - Emotional/Psychological
  - Communication
  - Mobility
  - Nutrition
  - Continence
  - Skin
  - Breathing
  - Medication
  - Conscious level

CHC checklist

Name of patient		Date of completion		
Please circle statement A, B or C in each domain	C	B	A	Evidence in records to support this level
Behaviour*	No evidence of 'challenging' behaviour. OR Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.	'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care.	'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	
Cognition	No evidence of impairment, confusion or disorientation. OR Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. OR Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	

Fast Track

- For patients with a rapidly deteriorating terminal condition where prognosis likely to be less than 3 months.
- Use indicators of decline.

Lancashire Teaching Hospitals NHS
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FAST TRACK EVIDENCE

STATEMENT:

The purpose of the Fast Track tool is to ensure that individuals who are felt to be entering a terminal phase, with a rapidly deteriorating condition are supported in their preferred place of care as quickly as possible (National Framework for Continuing Health Care 2012)

PATIENT DEMOGRAPHICS: **(Include name, NHS no: & DOB)**	**CONSULTANT NAME:**
DIAGNOSES (include all relevant):	
LIKELY PROGNOSIS: **(NB: It is expected that all disease modifying treatments will have been explored prior to this)**	
PROVIDE THE EVIDENCE TO SUPPORT THE PATIENT IS ENTERING A TERMINAL PHASE: **(NB: Whilst this is not time-specific, it would usually be considered to be less than 3 months).** **INCLUDE ANY PROGNOSTIC INDICATORS, INCLUDING ANY RADIOLOGICAL, BIOCHEMICAL OR PHYSIOLOGICAL EVIDENCE:**	
PROVIDE THE EVIDENCE TO SUPPORT THE PATIENT IS RAPIDLY DETERIORATING: **(NB: It is anticipated that this would be over a period of short weeks)** **INCLUDED EVIDENCE SUCH AS CHANGE IN PERFORMANCE STATUS, FUNCTIONAL ABILITY, PERFORMANCE OF ADLs, REQUIREMENTS FOR INCREASED SUPPORT ETC.**	
COMPLETED BY: ..... **SIGNED:** ..... (Insert name, profession & grade/band) **AGREED BY:** ..... (Insert name & grade of senior clinician)	

Rapid access

- For patients in the last hours-days of life.
- Same day/next day discharge.
- Involve palliative care team.

Finding a care home

- CH needs to be able to meet a person's needs (may need to meet future needs - especially at EoL)
- Funding needs to be in place
- Preference
- Market
- Residential/nursing
- EMD/EMI/CB unit

Whose responsibility is it to do this?

- Has capacity - patient / family
- Lacks capacity – family +- social worker
- No advocate – SW +- IMCA

Conflict in discharge planning

- Common!
- Tips:
  - Focus on the patients 'needs' (or best interests)
  - Sometimes we have to 'prove' the obvious to patients/family
  - Sometimes it's worth 'giving rehab a go'
  - Use principles of MCA
  - Be willing to explain the process but don't get involved with funding issues
  - Don't promise what you can't deliver!

More information

Factsheet 37

Hospital discharge

August 2018

Take home messages

- Think about your ‘exit strategy’
- As patients get better systematically remove ‘support’ (IV fluids, nebs, oxygen, lines, catheters, restraints)
- Mobilise ASAP (even if hoist to chair)
- Document weight-bearing status (and duration)
- Ask your therapists to see the patient before referring for rehab